CALIFORNIA MANAGED CARE IMPROVEMENT TASK FORCE
HIGHLIGHTS OF RECOMMENDATIONS
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The Task Force produced a substantial set of recommendations—roughly one hundred in all—that provide a framework for improving managed care for all Californians and help to rebuild trust in our health care system.

These recommendations respond to the concerns raised by citizens in testimony and in the state-wide public survey the Task Force commissioned to determine the experiences and perceptions of Californians related to managed health care. (Please see survey brief, as well as Public Experiences and Perceptions background paper).

Some will criticize the task force for being too modest. Others will say it was too radical. In fact, it produced a package of centrist, incremental proposals, that emerged as thoughtful compromises among highly opposed interests.

Recommendations address four major themes. Those listed below are the most important, heavily summarized from the Task Force report and proposed executive summary.

(a) **Improving Regulation:** Health care has a special moral status and therefore a particular public (i.e., government) interest.

(1) New regulator: A new state entity should be created to regulate HMOs currently regulated by the Department of Corporations, and to phase in regulation of other parts of the health care industry over time, including medical groups (and other organizations that bear significant risk), Preferred Provider Insurance, and individual clinical practitioners and health facilities. Regulation of quality of care should be centralized in the new entity. The entity should form a panel to establish statewide clinical best practices standards, a critical component of rigorous improvement in medical practice.

(b) **Making the Competitive Market Work for Consumers:** Competition can be a powerful tool in support of consumers' interests, but only if they have choices among health plans and providers, and information to exercise their choices intelligently.

(2) Purchasing groups: The State should facilitate the creation of purchasing groups to consolidate consumers' buying power and offer choices. The market reforms enacted in 1992-94 for employers with 2 to 50 employees should be extended to the 51 to 100 employee market.

(3) Risk Adjustment: The Task Force recommends that this more sophisticated payment method be employed in California as soon as possible. Risk adjustment pays providers according to the risk status of the population being cared for rather than on an average basis (so that doctors who treat sicker patients receive proportionately higher payments), and so that plans and providers are not encouraged to avoid higher-risk patients. By paying more accurately and fairly for needed care, risk adjusted payments guard against the potential for under-provision of care as well as incentives to avoid expensive patients. Specifically, the Task Force recommended that CalPERS adjust premiums for risk and that it be phased in for the UC system, large purchasing groups (such as the Pacific Business Group on Health and federal employees) and Medi-Cal.

(4) Standardizing Insurance Contracts: The inherent complexity of insurance makes it difficult for consumers to compare plans. Some standardization would help consumers and employers, who could save administrative costs. The new regulatory entity should fast-track standardized contracts, and should require that regulated plans compare their offering to one of five standard reference contracts to be developed by the regulator.

(5) New Quality Information: Consumers can't compare providers (and the health plans they contract with) based on objective, scientific quality of care information. Providers often lack the quality data they need to continuously improve care in a rigorous, disciplined way. The new regulatory entity should facilitate the conversion of medical records to electronic form by 2002-2004, subject to strict protections on patient confidentiality.

(c) **Improving the Quality of Care:** Most consumer complaints about managed care are related to their concern that health plans emphasize cost control at the expense of quality of care. The Task Force prepared a series of recommendations to improve quality.

(6) *Resolving Disputes Fairly and Efficiently:* Patients will not trust a system that does not handle complaints quickly and fairly. The new regulatory entity should have quality of care as one of its core missions, and should create complaint process standards that: are clear about time limits; offer customers examples of effective complaints; allow customers to participate personally in complaint hearings or conferences; publish reports on complaints to plans as well as the regulator; and offer a single phone number for customers to reach any relevant state regulator. Customers should receive a "bill of rights" when they enroll, including reimbursement for a qualified second opinion if they request it. Two regional ombudsman projects should be funded by the regulator. By 2000, the regulator should implement a third-party review process for grievances pertaining to medical

necessity/appropriateness and experimental treatments. Arbitration standards should include rapid selection of arbitrators, and appointment of neutral default arbitrators, required written opinions, and opt-out by consumers if plans have engaged in willful misconduct.

(7) *Disclose Providers' Financial Incentives*: Patient's confidence in their providers' decisions will be enhanced if they can learn about the scope of financial arrangements health plans create that can influence them. Plans should be required to disclose general methods and incentives paid to providers, and offer specific methods upon request. The regulator should develop appropriate disclosure language. Capitation of individual practitioners for a substantial portion of the cost of referrals should be prohibited. The regulator should ensure that practitioners at "substantial financial risk" have adequate protection against financial losses (e.g. stop-loss insurance or financial reserves).

(8) *Nurture the Physician-Patient Relationship*: A trusting, durable relationship between patient and provider is fundamental to health care delivery. To maintain continuity of care, plans and medical groups should reimburse care provided to chronically/acutely ill or pregnant patients when they involuntarily change plans or when their provider is terminated from a plan's network, up to a maximum 90 days or until a safe transfer to a new provider is implemented. Plans should allow extended or permanent referrals to specialists for patients with severe conditions who require continuing specialist care. Patients must consent to any appointments with a different provider than the one they chose. Plans and their contractors should be prohibited from requiring enrollees to waive confidentiality protections for commercial purposes.

(9) Encourage Consumers to Get Informed and Involved: Knowledgeable consumers, who press for continuous improvements in quality of care, customer service, and price, are the linchpin of a functioning competitive market. Plans should make available up-to-date information on provider access, treatment guidelines, and key features of their product. Employers should be encouraged to report on employee pay stubs the premium contributions, to increase employee awareness about the magnitude of health benefits costs. Plan accrediting bodies should develop standards for consumer information and involvement in health plans, and the regulator should incorporate plan member advisory committees in its oversight.

(10) Improving the Delivery of Care and the Practice of Medicine: Physicians and patients who agree on a course of treatment may find that decision altered by a health plan's utilization management entity. Plans should pre-credential providers based on objective standards of care, and provide automatic approval to eligible high-quality physicians. Prior approval should be eliminated for catastrophic conditions where there are accepted treatment protocols. Denials of care must include a review by appropriately credentialed individuals. The regulator should publish a report on progress toward this objective by 2000. Formularies should be periodically made available to enrollees, along with an exception process for obtaining non-formulary drugs. Patients with ongoing conditions should be able to continue receiving drugs removed from a plan's formulary. The regulator should convene a panel to certify best clinical practices and procedures for reclassifying formerly experimental procedures to establish statewide standards of excellence.

(11) Serving Vulnerable Populations: Vulnerable populations with special needs pose challenges for the health care system, whether managed care or fee-for-service. They are the "canary in the mine shaft", and should be tracked carefully as a bellwether for the quality and effectiveness of care for all Californians. Purchasers should identify and track the vulnerable sub-populations among their membership. The state should pilot initiatives to better integrate care for these groups, and should report on the quality and access to care being received by Medi-Cal recipients and Medi-Cal managed care's impact on the health system, especially safety net providers and public health education.

(12) Improving the Integration of Care: Case Study on Women: Managed care holds the promise of better coordination of care among different specialists and facilities. The Task Force made a number of recommendations intended to increase information available to female patients and improve integration of their care. The most significant is that women be permitted direct access to their OB/GYN in a manner that encourages coordination of service

(d) **<u>Background Findings</u>** Pursuant to the task Force's legislative charter, it also made findings regarding (14) managed care's role in the overall health industry, (15) its impact on the main yardsticks of health system performance (quality, access, and cost), and the impact of managed care on the physician-patient relationship and (13) on academic medical centers. In addition, the Task Force commissioned a major survey of the public's perceptions of and experiences with managed care (16), which are summarized in a separate handout.

Taken together, the Task Force's recommendations are a significant and valuable reform package that will:

- **streamline and improve government's role in the oversight and regulation;**
- **while simultaneously working through the competitive market to enhance managed care's best features:**
  - **-coordinated care delivered by highly skilled professionals,**
  - **-delivering cost efficient, patient-sensitive medicine,**
  - **-based on the best clinical information science can offer.**